DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
REGION IX

75 Hawthorne Street
Suite 408
San Francisco, CA 94105

NOV 13 2001

Phyllis Biedess, Director
Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, AZ 85034

Dear Ms. Biedess:

Enclosed is an approved copy of Arizona State plan amendment (SPA) 01-009, regarding fee-for-service payments to long term care facilities. I am approving this SPA with the requested effective date of October 1, 2001.

If you have any questions, please have your staff contact Ronald Reepen at (415) 744-3601.

Sincerely,

Linda Minamoto
Associate Regional Administrator
Division of Medicaid

cc:

Joan Peterson, CMS, CMSO, FCHPG
Elliot Weisman, CMS, CMSO, PCPG (two copies)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING FEE-FOR-SERVICE PAYMENT RATES FOR LONG TERM CARE FACILITIES

I. General Provisions

A. Purpose

This State Plan Amendment establishes the reimbursement system for fee-for-service payments to nursing facilities where payments are made directly by the Arizona Long Term Care System (ALTCS) or the acute care program. The method of updating the per diem rates established under this plan from year to year is amended effective for dates of service beginning October 1, 2001.

Under the ALTCS program, the fee-for-service rates established under this plan are used to reimburse facilities for services provided to Native American members with an on-reservation status (including prior period coverage). Under the acute care program, these fee-for-service rates are used to reimburse the acute care program's limited coverage of nursing facility services for Native American members.

B. Reimbursement Principles

1. Providers of nursing facility care are reimbursed based on a prospective per diem reimbursement system designed to recognize members in four levels:

   - Level 1
   - Level 2
   - Level 3
   - Ventilator dependent, sub-acute and other specialty care.

   Fee-for-service payments for services to members in nursing facilities who are ventilator dependent, sub-acute or receiving other specialty care are based on negotiated rates. Negotiated rates are based on the rates paid by program contractors for specialty care services and member service needs.

   Reimbursement for Levels 1, 2 and 3 is based on a three component system:

   - Primary Care - The primary care cost component reflects direct member care including wages, benefits and salaries for registered nurses (RNs), licensed practical nurses (LPNs), and nurse aides.

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- Indirect Care - Non-nursing, non-capital related activities of the nursing facility are included in the indirect care component. The activities reflected in this component are further removed from the delivery of member care and are less likely to vary based on the acuity level of an individual member (e.g., supplies, housekeeping, laundry, and food).

- Capital - The capital cost component includes depreciation, leases, rentals, interest and property taxes.

2. AHCCCS makes no fee-for-service payments to Intermediate Care Facilities for the Mentally Retarded (ICF/MR). ICF/MR services are reimbursed by the program contractor providing statewide Medicaid services for the developmentally disabled which is the Department of Economic Security/Division of Developmental Disabilities.

3. The AHCCCS fee-for-service program reimburses qualified providers of nursing facility services based on the individual Medicaid member's days of care multiplied by the lesser of the charge for the service or the applicable per diem rate for that member's classification, less any payments made by a member or third parties.

4. Reimbursement rates determined under this plan are effective for services rendered on or after October 1, 2001.

II. Rate Determination for Nursing Facilities

Per diem reimbursement for nursing facility services to members in Levels 1, 2 and 3 shall be the sum of three prospectively determined rate components:

A. Data Sources

1. Primary Care

When recalculation of the per diem reimbursement rates are determined appropriate by the Administration, several sources of data may be used in the calculation of the primary care rate component.

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- Arizona Pre-admission Screening (PAS) instruments (initial and reassessments) from the most recent six month period preceding the effective date of the rate. The data set excludes physician override cases. The PAS and reassessment instruments measure a member's level of functioning based on individual scores for Activities of Daily Living (ADL) items and medical service items.

- The Maryland Time and Motion Study of nursing time requirements by functional level and for specific nursing services and treatments.

- Salary and benefits for RNs, LPNs, and nurse aides from cost and/or wage reports submitted by Arizona nursing facilities for cost report years ending in the calendar year preceding the effective date of the rate.

- Primary care cost data from cost reports submitted by Arizona nursing facilities for cost report years ending in the calendar year preceding the effective date of the rate.

- BLS Employment Cost Index (ECI).

Because the primary care component varies by member level of care and geographic location, a total of six primary care rates are developed. An individual rate is developed for each of the member levels of care, 1 through 3, and these rates are adjusted for geographic wage variations in urban and rural areas. Maricopa, Pima and Pinal are defined as urban; the remaining 12 counties are defined as rural. Wage data is obtained from cost reports and does not depend in any way on Medicare wage indices.

2. Indirect Care Component

When recalculation of the per diem reimbursement rates is determined appropriate by the Administration, several sources of data may be used in the calculation of the indirect care component:

- The indirect care component from the previous rate year.

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- Indirect care cost data from cost reports submitted by Arizona nursing facilities for cost report years ending in the calendar year preceding the effective date of the rate.

- Consumer Price Index (Medical Care Services).

The indirect care component is a single statewide rate that does not vary by member level of care or geographic area.

3. Capital Component

When recalculation of the per diem reimbursement rate is determined appropriate by the Administration, several sources of data may be used in the calculation of the capital component:

- Capital component from the previous rate year.

- Capital cost data from cost reports submitted by Arizona nursing facilities for cost report years ending in the calendar year preceding the effective date of the rate.

- Skilled Nursing Facility Total Market Basket published by Data Resources Inc. (DRI).

The capital component also is a single statewide rate that does not vary by member level of care or geographic area.

The sections that follow provide specific details on the methodology used to calculate each of these rate components.

B. Rate Computation.
The following computations were used to update rates effective on and after October 1, 2001.

1. Primary Care

The steps used to calculate the primary care component include:

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- Step 1 - Classify Members. Members are grouped into Levels 1, 2, or 3 using a numeric score and weight assigned to each item on the PAS and reassessment instruments using a process called discriminant analysis. During the analysis each individual is assigned, based on their PAS record, to a member class reflecting the resources required by the member. In addition, a standard base amount of nursing minutes is assigned to each patient regardless of assessment score for meal preparation, night shift, etc.

- Step 2 - Evaluate Use of Services. After the ventilator dependent/sub-acute members are removed, the remaining members are evaluated using PAS data to quantify the types of services they need.

- Step 3 - Determine Nursing Time. Service needs are translated into time requirements using the Maryland Time and Motion Study. The linkage of member need and nursing time may be slightly modified based on a review of time assessments in prior years and variations in ADL measurements.

- Step 4 - Calculate Nursing Staff Times. Staff time equals the sum of nursing time, ADL weight plus an allocation of overhead. The result is an estimate of the fraction of an hour needed to provide nursing care in each member class. This is broken down into RN care, LPN care and nurse aide care.

- Step 5 – Assign Level of Care 1, 2, or 3. Medical and functional assessment data from the PAS instrument are used to assign each patient a medical and functional score. Based on these scores, patients are classified into a level of care. 4% of the members with the highest scores in each class are moved to the next highest level of care.

- Step 6 – Compute Average Nursing Minutes for each Level of Care. The total RN, LPN, and Nurse Aide time required for all patients in the same level of care are averaged.

- Step 7 - Translate Nursing Time into the Rate. In this step, the nursing times are translated into the rate component by multiplying the number of minutes for each nursing level for each level of care by average hourly wages.

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Wage data information is obtained from cost report and/or wage data submitted by Arizona nursing facilities for reporting years ending in the calendar year preceding the effective date of the rate. Wage data for registry nursing is included in these wage calculations but is capped based on thresholds of average urban and rural registry hour utilization. All wages associated with registry hours at or below the thresholds are included in the rate calculations. Wages are then increased to 105% of the mean.

- Step 8 - Inflate. Using the DRI market basket index, wages are inflated to the midpoint of the fiscal year in which the rate becomes effective (the end of the first quarter of the calendar year). Inflation is applied before outliers are excluded.

- Step 9 - Calculate Level of Care Rates for Urban and Rural. At the conclusion of this Step, six primary care rates exist. Rates for the three levels of care vary by geographic area.

2. Indirect Care Component

The steps to calculate the statewide average indirect rate per day include:

a) For each facility total capital costs are subtracted from total facility costs to determine costs without capital.
b) These remaining costs are inflated to the midpoint of the rate year using the Consumer Price Index (Medical Care Services).
c) Facility specific inflated direct care wage costs are subtracted from the value above to derive facility specific indirect costs.
d) For each facility the total indirect costs are divided by the total nursing facility days to calculate an indirect cost per day. An adjustment factor is applied to those facilities with an occupancy rate of less than 85% (based on total nursing facility bed days).
e) The facility-specific indirect costs per day are weighted by Title XIX nursing facility days to determine each facilities total Medicaid indirect costs. The sum of these weighted costs is used to calculate the statewide average indirect care cost per day. Facilities' with average indirect costs per day plus or minus 2 standard deviations from the mean are excluded.

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3. Capital Component

The steps to calculate the statewide average capital rate per day include:

a) Capital costs are obtained from the cost reports for each facility.
b) Facility specific capital costs are inflated to the midpoint of the rate year using the DRI Skilled Nursing Facility Total Market Basket.
c) For each facility inflated capital costs are divided by total facility-specific nursing facility days to calculate an average capital cost per day. An adjustment factor is applied to those facilities with an occupancy rate of less than 85% (based on total nursing facility bed days).
d) The facility-specific capital costs per day are weighted by Title XIX nursing facility days to determine each facilities total Medicaid capital costs. The sum of these weighted costs is used to calculate the statewide average capital cost per day. Facilities' with average capital costs per day plus or minus 2 standard deviations from the mean are excluded.

4. Total Rate

The per diem nursing facility rates are calculated by summing the primary care, indirect care, and capital cost components. These rates vary by member level of care and geographic area due to the primary care components.

5. Rate Update

Effective October 1, 2002 and each year thereafter, fee-for-service rates for nursing facilities may be updated by applying an inflation factor or factors to the rate components in effect for the prior year. This method of adjusting fee-for-service rates is consistent with the method used by AHCCCS for other medical services.

III. Other Provisions

A. Provider Appeals

Nursing facility providers have the right to request an informal rate reconsideration in accordance with the ALTCS Rules. Appeals are allowed for the following reasons:

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- Extraordinary circumstances (as determined by the Director).
- Provision of specialty care services directed at members with high medical needs.
- Unique or unusually high case mix.

Appeals are made in writing to the Director. Appeals which are granted become effective no earlier than the date the appeal was requested.

B. Cost and Wage Reporting

AHCCCS uses cost and wage reports filed by the nursing facilities in the State of Arizona as a basis for these rate calculations.

C. Audit Requirements

The AHCCCS periodically conducts audits of the financial and statistical records of participating providers. Specifications for the audits are found in the Arizona Long Term Care System (ALTCS) Uniform Accounting and Reporting System and Guide for Credits of ALTCS Contractors and Providers.

D. Rates Paid

Fee-for-service reimbursement for nursing facilities is made in accordance with methods and standards which are specified in this attachment of the State Plan.